

BENEFITS 2014	PARTICIPATING	NON-PARTICIPATING
Deductible and Out-of-Pocket Maximum		
Deductible (Single/Family)	\$1,000/\$2,500	\$1,500/\$3,000
Out -of- Pocket Maximum	\$4,000/\$8,000	\$6,000/\$12,000
<i>This amount is your deductible + co-insurance and copy</i>		
Inpatient Services		
Medical, Surgical, Hospice, Emergency Admission	20% after deductible	50% percent after deductible
Skilled Nursing Facility <i>Up to 60 days/calendar year</i>	20% after deductible	50% percent after deductible
Rehab Therapy: Physical, Speech, Occupational <i>Up to 40 days/calendar year for all therapies combine</i>	20% after deductible	50% percent after deductible
Lifetime Maximum Plan Payment	None	None
Professional Services		
Office Visits and Office surgeries		
Primary Care Provider (PCP)	\$25	50% after deductible (\$25 minimum copay)
Secondary Care provider (SCP)	\$40	50% after deductible (\$40 minimum copay)
Allergy Tests	See Office Visits	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Physicians Fees- <i>Medical,Surgical,Anesthesia</i>	20% after deductible	50% after deductible
Preventative Services outlined by the ACA		
Office visits (PCP/SCP)	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Diagnostic Test: Minor	Covered 100%	Not Covered
Other Preventative Services	Covered 100%	Not Covered
Pediatric Vision Service Ages 0-18 Years Only		
Routine Eye Exams	Covered 100%	Not Covered
Contacts and Corrective Lenses <i>Limit one pair of eyeglass lenses or contact lenses per year</i>	20% after deductible	50% after deductible
OUTPATIENT SERVICES		
Outpatient Facility and Ambulatory Surgical	20% after deductible	50% after deductible
Ambulance(Air or ground) <i>emergencies only</i>	20% after deductible	See participating benefit
Emergency Room Participating Facility	\$250 after deductible	See participating benefit
Emergency Room Non-Participating Facility	\$250 after deductible	See participating benefit
Chemotherapy, Radiation, Dialysis	20% after deductible	50% after deductible
Diagnostic Tests: Minor	100% covered	50% after deductible
Diagnostic Tests: Major	20% after deductible	50% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	50% after deductible
Outpatient Rehab/Habilitative Therapy: Physical,Speech, Occupational <i>Up to 20 visits /calendar year for each therapy type</i>	\$40 after deductible	50% after deductible
MISCELLANEOUS		
Maternity and Adoption <i>Includes all related maternity and adoption services</i>	See Professional, Inpatient, or Outpatient	See Professional, Inpatient, or Outpatient
Chiropractic Care <i>up to 15 visits/calendar year</i>	Not Covered	50% after deductible
Miscellaneous Medical Supplies (MMS)	20% after deductible	50% after deductible
Durable Medical Equipment(DME)	20% after deductible	50% after deductible
Injectable Drugs and Specialty Medications	20% after deductible	50% after deductible
Infertility (<i>select services only</i>)	50% after deductible	Not Covered

Maximum plan payment: Up to \$1,500/calendar year; \$5,000/lifetime

Mental Health and Chemical Dependency

<i>Inpatient</i>	20% after deductible	50% after deductible
<i>Outpatient</i>	20% after deductible	50% after deductible
<i>Residential Treatment Center</i>	Not covered	Not Covered

Cochlear Implants	See Professional, Inpatient, or Outpatient	Not Covered
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Donor Fees for Covered Organ Transplants	See Professional, Inpatient, or Outpatient	Not Covered
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TMJ (Temporomandibular Joint) Services <i>Up to \$2,000/lifetime</i>	See Professional, Inpatient, or Outpatient	Not Covered
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PRESCRIPTION DRUGS

Deductible	None
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Out-of-Pocket Maximum	Combined with medical
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Co-pay Up to 30-day supply for covered medications
generic substitution required

Tier 1	\$10
Tier 2	25%
Tier 3	50%
Tier 4	20%

Maintenance Drug -90-day supply
generic substitution required

Tier 1	\$10
Tier 2	25%
Tier 3	50%